NORTH CAROLINA GENERAL ASSEMBLY

BLUE RIBBON COMMISSION ON TRANSITIONS TO COMMUNITY LIVING

SUBCOMMITTEE ON ADULT CARE HOMES

Co-chairs:
Representative Nelson Dollar
Senator Stan Bingham

FINAL REPORT
TO THE
FULL COMMISSION

DECEMBER 12, 2012

TRANSMITTAL LETTER

The Blue Ribbon Commission on Transitions to Community Living was created by Session Law 2012-142, Section 10.23A, as amended by S.L. 2012-145, Section 3.6. The Commission was directed to appoint a Subcommittee on Adult Care Homes pursuant to S.L. 2012-142, Section 10.23A.(c).

The Subcommittee on Adult Care Homes respectfully submits the following report to the Blue Ribbon Commission on Transitions to Community Living.

Representative Nelson Dollar
Co-Chair

Senator Stan Bingham
Co-Chair

SUBCOMMITTEE MEMBERSHIP

Representative Nelson Dollar, Co-Chair

Representative William Brisson

Representative Mark Hollo

Mr. Hugh Campbell

Mr. Connie Cochran

Mr. Sam Hooker

Ms. Leigh Ann Kingsbury

Mr. Michael Watson, Director
Division of Medical Assistance, DHHS

Mr. Jim Jarrard, Director,
Division Mental Health, Developmental Disabilities and Substance Abuse Services, DHHS

Senator Stan Bingham, Co-Chair

Senator Peter Brunstetter

Senator Louis Pate

Mr. Mark Long

Dr. Peggy Terhune

Ms. Ann Medlin

Ms. Pam Shipman

Mr. Dennis Streets, Director
Division of Aging & Adult Services, DHHS

Staff

Dr. Patricia Porter, Consultant

Ms. Maria Kinnaird, Committee Assistant

Ms. Theresa Matula, Research Division

Ms. Amy Jo Johnson, Research Division

Mr. Donnie Charleston, Fiscal Research Division

Ms. Joyce Jones, Bill Drafting Division

Ms. Candace Slate, Committee Assistant

Ms. Sara Kamprath, Research Division

Dr. Patsy Pierce, Research Division

SUBCOMMITTEE PROCEEDINGS

The Blue Ribbon Commission on Transitions to Community Living, Subcommittee on Adult Care Homes, was created by S.L. 2012-142. S.L. 2012-142, Section 10.23A, subsections (a)-(c) and (h) are provided in the Appendix.

The Subcommittee met four times between September 12, 2012, and December 12, 2012. This section of the report provides a brief overview and a summary of the Subcommittee proceedings. Detailed minutes and copies of handouts from each meeting are on file in the legislative library and at the following link: http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=203

Overview of Topics and Presenters

September 12, 2012

- **Purpose and Anticipated Outcomes for Subcommittee**
  Chairman Dollar

- **Getting a Clear Picture of Adult Care Homes and Their Residents**
  Theresa Matula, Research Division

- **Challenges through the Industry Lens**
  Connie Cochran, CEO, Easter Seals UCP NC & VA
  Hugh Campbell, President, NC Association of Long Term Care Facilities
  Sam Hooker, Board Member, NC Assisted Living Association
  Peggy Terhune, CEO, Monarch NC

- **Update on Institutions of Mental Disease (IMD)**
  Sandy Terrell, Assistant Director, Clinical Policy & Programs, Division of Medical Assistance, DHHS

- **Directed Discussion by Subcommittee Members**
  Chairman Dollar

October 10, 2012

- **Summary of Responses to Questions Posed to Subcommittee**
  Pat Porter, HHS Consultant
  Patsy Pierce, Research Division

- **Institutions of Mental Disease (IMD): Update**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS

- **Status of Personal Care Service (PCS) Eligibility and Independent Assessment Process**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS

- **Adult Care Home Discharge Planning Process and Timeline**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS

- **Presentation of Current and Potential Funding Options for Intellectual/Developmental Disability (IDD) and Mental Health Supervised Living Facilities (Group Homes)**
  Pam Shipman, CEO, Cardinal Innovations Healthcare Solutions
  Karen Adams-Gilchrist, Chief Program Officer, Easter Seals UCP NC & VA

November 14, 2012

- **Restatement of Subcommittee's Purpose, Review of Information Covered, and Summary of Current Situation**
  Chairman Dollar

- **Brief Update on IMD Determinations**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS

- **PCS Assessments: Status of Notification, Breakdown of Data**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS

- **Potential New and Expanded Service Options by Setting, Facility Size and Population: Licensed and Unlicensed for SPMI/SMI/IDD**
  Tara Larson, Chief Clinical Operating Officer, Division of Medical Assistance, DHHS

- **State-County Special Assistance: Overview of Program and Medicaid Eligibility Criteria Issue**
  Suzanne Merrill, Division of Aging and Adult Services, DHHS

- **A Comparison of Adult Care Home Funding Strategies**
  Donnie Charleston, Fiscal Research

- **Trends in Funding Adult Care Homes and Multi-Unit Assisted Housing with Services**
  Janet O'Keefe, DrPH, Senior Researcher and Policy Analyst, RTI International

Summary of Subcommittee Proceedings

September 12, 2012

Chairman Dollar gave an overview of the purposes of the Subcommittee. Those purposes included: (1) review of the current status of adult care homes (ACHs), (2) determination of impact of designation of a facility as an Institution of Mental Disease (IMD) and changes in Medicaid Personal Care Services (PCS) eligibility, (3) delineation of a clear and coordinated process for discharge and community placement for individuals no longer appropriately served by ACHs, (4) review of service and support funding options, and (5) identification of possible alternative best practice models of services for ACHs that cannot be sustained in their current operation. He also informed the members that later they would hear from a panel of Subcommittee members representing the adult care homes and group homes industries.

Theresa Matula, Subcommittee staff, Research Division, North Carolina General Assembly (NCGA), explained that North Carolina faces the possibility of board and care residents being impacted, and possibly relocated, based on three issues: PCS eligibility changes, identification of IMDs, and the United States Department of Justice (US DOJ) Settlement Agreement. In an effort to assist the Subcommittee in defining the range and depth of facilities involved in these issues, Ms. Matula provided the Subcommittee with an overview of the various licensed facilities. She provided statutory references and descriptions of the following: Supervised Living Facilities (Group Homes) and Adult Care Homes (including Family Care Homes, 55+ licensed facilities, Special Care Units, and Combination Homes). Utilizing data supplied by the Division of Health Service Regulation, Department of Health and Human Services (DHHS), Ms. Matula provided the Subcommittee with the numbers of licensed facilities and beds in these categories.

Connie Cochran, CEO, Easter Seals UCP NC & VA; Hugh Campbell, President, NC Association of Long Term Care Facilities, Sam Hooker, board member NC Assisted Living Association, and Dr. Peggy Terhune, CEO, Monarch NC, each described the specific populations being served, funding sources used, and types of facilities under their organization's purview. They each discussed the impact of issues relating to PCS, IMD determination and the recent US DOJ Settlement Agreement. Finally, they each provided possible solutions for residents in their facilities who may be at risk for losing services and housing due to these issues.

At the request of Sen. Brunstetter, Emory Milliken, General Counsel, DHHS, was asked to provide comments from a legal perspective on the IMD issue as well as the US DOJ settlement issue. Ms. Milliken stated that the US DOJ investigation of our mental health system found that North Carolina, in their opinion, had an institutional bias towards keeping people in institutional settings rather than in communities. She also said that the process the Division of Medical Assistance (DMA), DHHS is following is consistent with the law and if we did anything differently this could impact the US DOJ Settlement Agreement.

Ms. Sandy Terrell, Assistant Director, Clinical Policy & Programs, DMA, DHHS, provided an update on shared ownership, the IMD process, and the status of the group homes. She described the screening process and analysis of data required to make a final determination of whether a facility is determined to be an IMD. The process involves looking at the occupied beds as well as the overall characteristics of the facility. Ms. Terrell indicated that the corrective action plan originally was supposed to be completed by August 31, but due to the methodology change directed by the Centers for Medicare & Medicaid Services (CMS) to review the occupied beds versus the licensed beds, a new date for completion is still under negotiation with CMS.

Ms. Terrell gave an update on the facilities potentially at risk in Phase II of the IMD investigation: 84 adult care homes, 52 family care homes, 47 group homes.

October 10, 2012

Ms. Tara Larson, Chief Clinical Operating Officer, DMA, DHHS provided updates on two of the three major issues facing the State in relation to housing and services for elderly adults and for adults with mental illness and/or intellectual or developmental disabilities. First, Ms. Larson addressed the IMD determination issue and indicated that, at the time of this presentation, 151 facilities had been identified as possibly meeting the definition of an IMD. The proposed timelines for IMD determination completion must be approved by CMS and include:

- Adult Care Homes: 11/30/12
- Family Care Homes: 2/28/13
- 122C Group Homes/Supervised Living Facilities: 6/30/13
- Family Care Homes or 122C Group Homes on the same property by 11/30/12

Ms. Larson continued with her presentation on the IMD determination by outlining how DMA determines if multiple facilities fall under "shared ownership," including components such as licensure, ownership, governance/administration, and medical responsibility. Ms. Larson concluded her presentation on IMD determination by discussing the preliminary injunction the Office of Administrative Hearings had enjoined against DHHS/DMA.

Second, Ms. Larson provided a detailed description of the PCS eligibility Independent Assessment (IA) process. She indicated that to date, 13,171 IAs had been completed, and of the 8,781 that had been analyzed and entered into the system, 48% of those assessed would no longer qualify for PCS under the new eligibility criteria scheduled to begin January 1, 2013.

Ms. Larson concluded her remarks with a description of the discharge process for individuals currently residing in Adult Care Homes in case the ACH is found to be an IMD.

Ms. Pam Shipman, CEO, Cardinal Innovations Healthcare Solutions, and Ms. Karen Adams-Gilchrist, Chief Program Officer, UCP/ Easter Seals, presented possible solutions for how persons with Serious Mental Illness (SMI) and Serious and

Persistent Mental Illness (SPMI) may be able to live more independently. Ms. Shipman's ideas included continuing Geriatric Adult Specialty Teams but using them in admissions, discharge, and transition processes. She also indicated a need for new service definitions including: supported employment, peer support, assistive devices, and residential supports. Additionally, Ms. Shipman suggested that a funding source for these new services could be utilizing funds currently being used for group homes for persons with mental illness as a state match either as a b-3 or State Plan service. Ms. Adams-Gilchrist suggested stabilizing current funding and submitting a request for an (i) option waiver for the Intellectually/Developmentally Disabled (IDD) target population to fund transition services.

Public members of the Subcommittee were previously asked to respond to a set of discussion questions. Dr. Pat Porter summarized the responses which indicated needs and solutions for housing and services; and supports and funding for the frail elderly and for adults with disabilities who may be affected by the PCS, IMD, and DOJ issues.

November 14, 2012

Chairman Dollar began the meeting by reiterating the purposes and goals of the Subcommittee.

Ms. Tara Larson, Chief Clinical Operating Officer, DMA, DHHS, provided an update on the IMD determination process indicating that there are 46 ACH facilities that still need to be reviewed by November 30, 2012. Of the facilities reviewed thus far, several have converted to Special Care Units, four remain under preliminary injunction, and several others have been determined not to be IMDs.

Ms. Larson also provided an update on PCS independent assessments. She indicated that persons who no longer qualify for PCS can use private funds, if available, to cover the needed assistance. She also outlined options for ACHs to use to continue to provide room, board and services such as converting to multiunit assisted housing with services (MAHS). Ms. Larson continued her presentation by providing the detailed results of IAs completed at this time. Approximately 9,322 persons across all types of facilities appear to no longer qualify for PCS. She provided a handout including summary and specific facility data. Ms. Larson indicated that DMA has been providing PCS and IMD data to local department of social services (DSS) agencies. She also provided specifics on different State funding sources and possible Medicaid State Plan amendments for additional funding for needed services.

Ms. Suzanne Merrill, Adult Services Section Chief, Division of Aging and Adult Services, DHHS, provided details about the State-County Special Assistance-Adult Care Home (SA-ACH) program. State-County Special Assistance provides a cash payment to supplement an individual's income to live in adult care homes licensed under Chapter 131D of the General Statues, and Supervised Living Facilities (Group Homes) licensed under Chapter 122C of the General Statutes and defined in 10A NCAC 27G.5601 to serve adults whose primary diagnosis is mental illness but may

also have other diagnoses (5600a) and to serve adults whose primary diagnosis is a developmental disability but may also have other diagnoses (5600c). SA-ACH covers expenditures not related to PCS (e.g salaries and benefits for non-PCS staff, housekeeping, food, supplies, depreciation or rent, repairs, insurance, equipment, linens, etc.). Medication administration is not covered by SA.

Ms. Merrill also described the SA In-Home program which covers expenses to support a person living safely at home. Needs are determined by a local DSS case manager and may include expenditures such as rent, utilities, and personal assistance in the home. Ms. Merrill's presentation included an overview of recent changes (S.L. 2012-142, Section 10.23) to SA In-Home. The changes include equalization of SA In-Home payments with SA-ACH. Previously SA In-Home payments were 75% of SA-ACH, effective July 1, 2012 the payments are 100%. Additionally, she highlighted how counties pay for the administrative costs for SA In-Home and she provided a breakdown of SA cases by setting: ACH (52%); Family Care Home (9%); Special Care Unit (12%); Supervised Living Facility/Group Home – for the mentally ill (8%); Supervised Living Facility/Group Home – for the developmentally disabled (10%); and SA In-Home (6%).

Finally, Ms. Merrill provided information on the relationship between SA and Medicaid. She explained that SA-ACH is an Optional State Supplement (OSS) to the Social Security's Supplemental Security Income (SSI) program. Since Medicaid is automatic for SSI recipients, SA-ACH residents receive Medicaid. However, SA In-Home was established by the NC General Assembly and is not part of the OSS program. As a result, SA In-Home residents must qualify for full private living Medicaid. The DHHS estimates that approximately 27% of all SA recipients in licensed facilities have income above the federal poverty level and will not qualify for Medicaid in a private living setting. Ms. Merrill provided information on how North Carolina compares with other states on implementation of the OSS program: six (6) states provide supplements only to individuals in private living settings; 16 states provide supplements only to individuals in residential care settings (includes NC), 22 states provide supplements to individuals in both residential care settings and private living settings, and six (6) states do not participate in the OSS program.

Donnie Charleston, Subcommittee staff, Fiscal Research Division, NCGA, provided an overview of ACH funding used in other states, as compared to those used in NC. Comparison states were chosen based upon similar domiciliary requirements. He indicated that the comparison states use five options to fund ACHs: (1) Medicaid State Plan Services, (2) 1915(c) waiver, (3) 1115 Demonstration Programs, (3) 1915(i) waiver, and (5) state revenue. He indicated NC had a significantly larger number of ACH residents compared to the other states used in the study. Mr. Charleston also gave rankings on the amounts spent on PCS by a number of states, including NC, and indicated that NC's PCS expenditures had risen more than those of the comparison states since 1999. He outlined State and federal legislation and audit activity to try to meet, limit, and control PCS funding needs. Mr. Charleston also provided comparative information on the amount of state funds (Special

Assistance) provided to ACHs. He concluded his remarks by explaining "cost modeling rate methodology" to determine Special Assistance rates.

Dr. Janet O'Keefe, Senior Researcher and Policy Analyst, RTI International, shared her opinion on some of the reasons NC is in the current situation with CMS regarding PCS, IMDs, and the US DOJ Settlement Agreement. She indicated that NC's definition of "nursing facility" is more stringent than in other states. She recommended that NC consider an "(i)" waiver to help address the needs of adults with Severe Mental Illness, especially now that, under the Affordable Care Act, the (i) waiver can serve those with lesser levels of impairment. Dr. O'Keefe also recommended that NC lower nursing home eligibility criteria in an effort to serve additional people and receive additional federal funding in those facilities. She suggested that NC pay a higher PCS In-Home rate, and that NC use licensing rules to address varying levels of need. Overall, Dr. O'Keefe said that NC needs to rethink how the adult care system is structured, especially with the growing aging population having long-term care needs.

The Subcommittee members commented and discussed various issues.

December 12, 2012

The Subcommittee met on December 12, 2012 to discuss a draft report. The final meeting of the Blue Ribbon Commission on Transitions to Community Living is scheduled for December 19, 2012.

SUBCOMMITTEE FINDINGS AND RECOMMENDATIONS

The findings and recommendations below are based on information provided to the Blue Ribbon Commission on Transitions to Community Living, Subcommittee on Adult Care Homes, during its regularly-scheduled meetings. Many of the issues explored by this Subcommittee continue to evolve. The recommendations included in this report request the Blue Ribbon Commission on Transitions to Community Living to direct the Department of Health and Human Services to explore specific issues that may need further study or action in the near future. The recommendations require reports to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Health and Human Services. These Committees should follow-up on the recommendations contained in the report as they deem necessary and appropriate to their work.

FINDING 1:

During the Blue Ribbon Commission meeting on September 5, 2012, the Commission, which included members of the Adult Care Homes Subcommittee, heard a presentation on the Americans with Disabilities Act (ADA) and the *Olmstead* Decision. The Commission also heard a presentation on the Settlement Agreement between the United States Department of Justice and the State of North Carolina. One of the substantive provisions provided in the US DOJ Settlement Agreement is as follows:

> "The State agrees to develop and implement effective measures to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports identified through person centered planning in the most integrated setting appropriate to meet the needs of individuals with SMI [Serious Mental Illness], who are in or at risk of entry to an adult care home, pursuant to the details and timelines set forth below."

During the Subcommittee meeting on September 11, 2012, members heard presentations on adult care homes and the challenges they face. Theresa Matula, Subcommittee staff, provided information on adult care homes and their residents which was based on data provided by the Division of Health Service Regulation. Ms. Matula's presentation included a breakdown of the numbers of beds and facilities by county and in the State as a whole. A panel of Commission members representing various types of facilities provided information on residents; funding sources; and the combined impact of the requirements of the US DOJ Settlement Agreement, the designation of some facilities as Institutions of Mental Disease, and

the potential impact of the Medicaid Personal Care Services eligibility criteria and independent assessments. The panel was also provided an opportunity to suggest possible solutions for the people who reside in the facilities and for the industry. Suggestions from representatives of the adult care home industry included the following: alternative funding streams that are not Activities of Daily Living (ADL) driven to serve the individuals residing in Adult Care Homes (ACH) who do not need ADL assistance but do require ACH level of care; Secure the I-Option for Adult Care Home Special Care Units (SCU); explore adding Fair Rental Value type incentive program to encourage providers to reinvest in the physical plant; and allow ACH beds approved under Certificate of Need (CON) rules to provide alternative housing options – such as 16-bed conversions for Mental Health services.

During the November 12th meeting, the Subcommittee heard a presentation by Dr. Janet O'Keeffe, Senior Researcher and Policy Analyst, RTI International. Dr. O'Keeffe questioned whether North Carolina should examine its continuum of care and perhaps evaluate adjustment of the admission criteria for nursing homes, licensed under Chapter 131E of the General Statutes. She suggested that if such an evaluation resulted in a need for more nursing homes, a conversion of some adult care homes to nursing homes could be an option.

The Subcommittee is concerned for individuals who depend on services, and the responsibility of the State to ensure that a range of services is provided to meet the needs and preferences of consumers. Therefore, the Subcommittee makes Recommendation 1 to direct the Department of Health and Human Services to explore alternatives for large adult care homes.

RECOMMENDATION 1: EXPLORE ALTERNATIVES FOR LARGE ADULT CARE HOMES

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living recommends the Blue Ribbon Commission direct the Department of Health and Human Services to work with the adult care home industry to explore business and service delivery alternatives for repurposing large (16+ bed) adult care homes. The Department must explore, but is not limited to, the following options: a Request for Proposal (RFP) process and funding to transition adult care homes to alternative service options; expansion and/or transition to address the needs of special populations (e.g. traumatic brain injury); options tied to any changes in restructuring of the skilled nursing facility and adult care home continuum; and all methods for reducing the number and costs of large adult care home facilities. The Department shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, on or before September 1, 2013.

FINDING 2:

On November 14, 2012, the Subcommittee heard a presentation on State-County Special Assistance by Suzanne Merrill, DAAS, DHHS. Ms. Merrill reported that the State-County Special Assistance for Adult Care Homes (SA-ACH) program is an Optional State Supplement (OSS) program to the Social Security Income (SSI) program. In North Carolina, Medicaid is automatic for SSI recipients under an agreement with the Social Security Administration. Therefore, recipients eligible for SA-ACH are automatically eligible for Medicaid. SA-ACH is available to eligible residents of adult care homes licensed under Chapter 131D of the General Statutes, and residents of supervised living facilities, licensed under Chapter 122C of the General Statutes, and as defined in accordance with 10A NCAC 27G.5601, that serve adults whose primary diagnosis is mental illness but may also have other diagnoses, and that serve adults whose primary diagnosis is a developmental disability but may also have other diagnoses.

By contrast, the State-County Special Assistance In-Home program (SA In-Home) was established by the North Carolina General Assembly and is not part of the OSS program. Individuals receiving SA In-Home must qualify for Medicaid separately. Due to varying requirements, residents living in adult care homes end up having lower income eligibility requirements for Medicaid than the individuals receiving SA In-Home. If SA-ACH residents are discharged from facilities and end up in a non-facility setting, the individual loses the automatic eligibility for Medicaid that accompanied their SA-ACH. These individuals may qualify for SA In-Home, but Medicaid would no longer be automatic and they would be required to apply for Medicaid. The DHHS estimates that 27% of all SA-ACH recipients would not qualify for Medicaid if transitioned to SA In-Home and required to meet the higher income eligibility criteria. As such, the Subcommittee makes Recommendation 2 to mitigate the loss of Medicaid eligibility by those exiting an adult care home.

RECOMMENDATION 2: MITIGATE THE LOSS OF MEDICAID ELIGIBILITY BY THOSE EXITING AN ADULT CARE HOME

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to consider all options to mitigate the loss of Medicaid eligibility by those exiting an adult care home and no longer receiving State County Special Assistance as an adult care home resident for this specific population for a set period of time. The Department must explore, but is not limited to, the following options: the implications of tying the receipt of SA In-Home to Medicaid eligibility as is the current practice for SA-ACH recipients; acquiring a federal disregard for residents moving from a facility to a home to allow a waiver of their deductible; and investigating the Medicaid Health Insurance Premium Payment Program provision to determine whether Medicaid can pay the "premium" for these individuals so they remain Medicaid eligible. The Department shall report findings and recommendations to the Senate Appropriations Committee

on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

FINDING 3:

Long-term care service options, the range of services, and the corresponding admission or eligibility criteria was a common theme throughout the Subcommittee's meetings. During the September 12th panel discussion, a representative of the adult care home industry provided that, "There needs to some type of acuity-based reimbursement system. If not, individuals with the lowest needs will end up in the most expensive service settings. Conversely, residents with some of the greatest needs will end up remaining in ACHs." During the November 12th presentation by Dr. Janet O'Keeffe, Senior Researcher and Policy Analyst, RTI International, she questioned whether North Carolina should examine its continuum of care and she gave examples of how some other states are structured. Dr. O'Keeffe discussed North Carolina's nursing bed admission criteria, the amount of State-County Special Assistance provided to facilities, and adjustment of the eligibility criteria for nursing homes licensed under Chapter 131E of the General Statutes. Dr. O'Keeffe suggested that more stringent admission standards for nursing homes may prevent North Carolina from applying for more waivers to cover certain individuals. One of the states mentioned by Dr. O'Keeffe was Florida which has three levels of care. As a result of the information shared by all, the Subcommittee makes Recommendation 3 to establish a long-term care continuum workgroup.

RECOMMENDATION 3: ESTABLISH A LONG-TERM CARE CONTINUUM WORKGROUP

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to establish a workgroup including stakeholders, Departmental personnel, and unbiased experts, to explore changes to North Carolina's long-term care continuum, including, but not limited to: expansion of waiver options and potential new licensure structure, and assuring that individuals are not unduly offered more restrictive placements than needed and are assured of receiving skilled nursing care as designated through assessment. The Department must make an interim report on or before April 1, 2013, and a final report of findings and recommendations on or before October 1, 2013, to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Health and Human Services.

FINDING 4:

The Subcommittee heard numerous presentations on the Medicaid Personal Care Services (PCS) changes for residents of licensed facilities and the status of the independent assessment process. The Subcommittee received information during the November 14th meeting on the numbers and percentages of individuals that will not qualify for Medicaid PCS on January 1, 2013. Also during the November 14th meeting, the DHHS provided responses to questions about care and supplementing care in an adult care home. The Department provided the following, "The licensed adult care home is responsible for care and services planned and provided to the resident. If the facility does not employ their own staff to provide scheduled personal care services they could contract for services through a licensed home care agency, but they would remain responsible for the quality and delivery of those services." The DHHS was asked specifically if family members could contribute to the cost of care for a family member who is a resident of an adult care home and not jeopardize Special Assistance. The response was, "The question has been researched in terms of SSI's and NC's Optional State Supplement Program (SA) and continued Medicaid eligibility and a family's voluntary payment to a facility for personal care would not be counted as income for SSI and our State Supplement Program (SA) nor would it be counted as income for Medicaid." Consistent with these findings, the Subcommittee provides Recommendation 4 to direct DHHS to explore establishing a process to allow a supplement to be paid by an individual or family member on behalf of an adult care home resident for a recipient that has lost eligibility for Medicaid Personal Care Services.

RECOMMENDATION 4: EXPLORE A SUPPLEMENT TO BE PAID ON BEHALF OF AN ACH RESIDENT

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to explore establishing a process to allow payment by an individual or family member on behalf of a recipient of State-County Special Assistance when that recipient has lost their eligibility for Medicaid Personal Care Services (PCS), and those Medicaid PCS services are not covered under a Medicaid appeal process. The Department shall report findings and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

FINDING 5 AND 6:

During the course of its existence, the Subcommittee monitored the Medicaid Personal Care Services (PCS) independent assessment process for licensed facility residents. On November 14th, the Subcommittee received a report of independent assessments completed as of October 26, 2012. The data provided the number of

assessments processed by setting, and the number and percentage of individuals qualifying for the new PCS criteria and those not qualifying. Additionally, this data provided: the age distribution of non-qualified beneficiaries; a diagnosis summary with percentages reflecting the diagnosis category selected by attesting practitioners; the average number of activities of daily living (ADLs) needed for those that qualified and those that do not; the numbers of hands-on ADL needs for those that qualify and those that do not; and the personal care needs of PCS non-qualified beneficiaries. For those not qualifying for PCS, the information indicated what percentage of residents in a particular care setting needed supervision/cueing, or hands-on assistance, for the following needs: bathing, dressing, mobility, toileting, eating, and medication management. The changes to PCS for facilities enacted in S.L. 2012-142, Section 10.9F, as amended, are effective January 1, 2013. Should the State decide to add a layer of service at a later date, the independent assessment data and the information requested in Recommendations 5 and 6 would facilitate such an option. Recommendation 5 directs the DHHS to investigate tiered PCS with eligibility criteria and a related rate structure tied to the assessed intensity of need and to explore coverage for medication management and for those individuals with Alzheimer's disease or related dementias. The second part of Recommendation 6 requires the DHHS to investigate the feasibility of a tiered State-County SA rate structure to address assessed resident needs based on the intensity of need, including medication management. Exploring both alternatives would provide the State with the ability to determine the best course of action, if any further action were desired.

The Subcommittee explored the interrelationship between the different funding streams for long term care (Medicaid and State revenue). Presentations by staff and outside experts examined the State-County SA program and its cost methodology, as well as the history of Medicaid PCS. The presentations showed that North Carolina stands out as having a high level of SA expenditures relative to other States with similar adult care home structures. North Carolina is responsible for approximately 20% of the nation's Medicaid funded ACH residents and has a high level of PCS expenditures. The historic funding overview provided during the meeting on November 14th, depicted how the nature of the two programs have changed relative to their original scope and intent. As contained in Recommendation 6, the Subcommittee recommends the Department of Health and Human Services study State-County Special Assistance to develop alternative cost methodology options for determining rates.

RECOMMENDATION 5: STUDY TIERED PERSONAL CARE SERVICES

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services investigate tiered Medicaid Personal Care Services with eligibility criteria and a related rate structure based on assessed intensity of need. The Department shall consider coverage for medication

management and for those individuals that have Alzheimer's disease or related dementias, and shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, on or before October 1, 2013.

RECOMMENDATION 6: STUDY STATE-COUNTY SPECIAL ASSISTANCE RATE STRUCTURE

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services study State-County Special Assistance to: 1) develop alternative cost methodology options for determining rates, and 2) to investigate the feasibility of a tiered rate structure to address assessed resident needs based on the intensity of need, including medication management. The Department shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services, and to the Senate Appropriations Committee on Health and Human Services and House Appropriations Subcommittee on Health and Human Services, on or before October 1, 2013.

FINDING 7:

On November 14, 2012, the Subcommittee heard Ms. Tara Larson, DMA, DHHS, explain that planning continues on the Medicaid 1915(i), or Medicaid "I", waiver application for adults with Intellectual and Developmental Disabilities (IDD). A draft submission by the Department to CMS will address a target population and eligibility criteria to capture those individuals not meeting the eligibility criteria for the regular Medicaid State Plan PCS services. The first service to be included on the Medicaid 'I" option will be a personal assistance definition focusing on habilitation (training, cueing, prompting) of ADLs, or hands on assistance to complete the ADLs. Additionally, the service definition will include instrumental activities of daily living (IADLs) associated with completion of the ADLs such as: meal preparation, setting up supplies for bathing, or cleaning up the bathroom once the bath is completed. In order to reduce the duplication of assessment on recipients and to reduce the burden on providers, the data from the assessments used to assess recipients for Medicaid PCS will be used to determine eligibility under the new Medicaid "I" option.

Ms. Larson told the Subcommittee that the draft outline will be submitted to the Centers for Medicare & Medicaid Services (CMS) by November 30, 2012. Once the initial Medicaid "I" option is approved and implemented by the target date of July 1, 2013, simultaneous planning will continue for an additional two services under the option: meaningful day activity and respite. The Committee heard Ms. Larson say that the January 1, 2013 through July 1, 2013 planning period will allow for: (1) more accurate cost modeling, (2) more accurate predictability of the number of people to be served to ensure cost neutrality of Medicaid funding, and (3) leveraging of State funds. She said that DHHS would like to include the Medicaid "I" option

under the 1915(b)(c) waiver so that all funding sources for IDD would be under the managed care option and overall cost data for services to people with IDD could be provided.

Additionally, Ms. Larson informed the Subcommittee that legislative authorization will be required for submission of the Medicaid "I" option for IDD. She said that draft submissions may be sent to CMS in order to receive feedback, but that official submission to CMS means that the State has the required funding in place and legislative authority to proceed. She said that no planning for submission of a Medicaid "I" option has begun for any other population and reiterated that legislative authority would be required for submission of a Medicaid "I" option for any other population.

RECOMMENDATION 7: HABILITATION SERVICES FOR IDD ADULTS

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to prepare a Medicaid "I" option application with a narrow focus on habilitation services for adults with intellectual and other developmental disabilities. Eligibility for this "I" option must be carefully constructed to consider assessed needs of the individual and to assure that these needs do not meet the criteria and intensity of need for ICF-IDD level of care. This Medicaid "I" option should be incorporated into the support needs process and the management and capitation of the LME/MCOs. Additionally, cost containment and comparability must be addressed, and projections for costs and number of eligible recipients must be provided when the application draft is submitted for review to the Senate Appropriations Committee on Health and Human Services, and House Appropriations Subcommittee on Health and Human Services, on or before February 1, 2013. The Department shall not take further action on the application until there is approval by the NC General Assembly.

FINDING 8:

During the October 10, 2012 meeting, the Subcommittee heard from Pam Shipman, Cardinal Innovations LME/MCO about their use of 1915(b)(3) funding options. She explained that additional habilitative services, such as supported employment, can be provided to persons with mental illness and/or intellectual/developmental disabilities by using monies saved through managed care implementation. Ms. Shipman provided detailed handouts describing services that may be funded through 1915(b)(3) authority.

On November 14, 2012, the Committee heard from Tara Larson that the 1915(b)(c) waiver is in process on the regular renewal schedule. All MCOs will have the B-3 services of respite, peer support specialist, and community guide. Piedmont

Behavioral Healthcare/Cardinal Innovations will have the following additional b-3 services: in-home skill building for people with IDD, comprehensive services for women with substance abuse, and transitional living for children.

Ms. Larson indicated that supported employment will begin as a State-funded service limited to three sites that will meet the fidelity model identified in the US DOJ Settlement Agreement. Once start-up is completed and fidelity is met, then supported employment will be added as a 1915(b)(3) service for implementation in July 2014. The Subcommittee also learned from Ms. Larson that DMA is reviewing the possibility of adding one-time transitional cost as a b-3 service. She stated that these transitional costs would be limited to a specific dollar amount and could be used to assist with deposits and needed furniture purchases to enable the person to move into a supported housing arrangement. The Subcommittee provides Recommendation 8 to direct the DHHS to explore service delivery options for individuals with mental illness to include expansion and addition of 1915(b)(3) services and adding new service definitions to the Medicaid State Plan upon approval of the NC General Assembly.

RECOMMENDATION 8: EXPLORE SERVICE DELIVERY OPTIONS FOR INDIVIDUALS WITH MENTAL ILLNESS

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the Department of Health and Human Services to expand upon and develop new service definitions and delivery options to meet the needs of individuals with a primary diagnosis of mental illness by: (1) considering an addition and expansion of 1915(b)(3) services, and (2) adding new service definitions to the Medicaid State Plan upon approval of the NC General Assembly. The Department shall present findings, anticipated costs, and recommendations to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

FINDING 9:

During the November 14th meeting, the Subcommittee heard from Tara Larson that the Innovations waiver expansion has been submitted to CMS for approval. An additional 250 slots have been submitted for approval as allowed in the certified Medicaid budget for this Fiscal Year. Slots that were already in the system but were "frozen" have been unfrozen and are available for use. Consistent with this information, the Subcommittee provides Recommendation 9 regarding CAP-IDD (Innovations) Medicaid waiver slots.

RECOMMENDATION 9: CAP-IDD (INNOVATIONS) MEDICAID WAIVER SLOTS

The Subcommittee on Adult Care Homes, Blue Ribbon Commission on Transitions to Community Living, recommends the Blue Ribbon Commission direct the

Department of Health and Human Services to expand the number of available CAP-IDD (Innovations) Medicaid Waiver slots within current funding and to unfreeze current slots within current funding constraints. The Department shall report on the status of the CAP-IDD (Innovations) waiver slots to the Senate Appropriations Committee on Health and Human Services, and the House Appropriations Subcommittee on Health and Human Services, on or before March 1, 2013.

APPENDIX

Authorizing Legislation

S.L. 2012-142
Section 10.23A, Subsections (a)-(c) and (h)

TRANSITIONS TO COMMUNITY LIVING INITIATIVE

SECTION 10.23A.(a) The General Assembly finds that the State's long-term care industry plays a vital role in ensuring that citizens are afforded opportunities for safe housing and adequate client-centered supports in order to live as independently as possible in their homes and communities across the State. This role is consistent with citizens of the State having the opportunity to live in the most appropriate, integrated settings of their choice. The General Assembly also is committed to the development of a plan that continues to advance the State's current system into a statewide system of person-centered, affordable services and supports that emphasize an individual's dignity, choice, and independence and provides new opportunities and increased capacity for community housing and community supports.

SECTION 10.23A.(b) Blue Ribbon Commission on Transitions to Community Living. – There is established the Blue Ribbon Commission on Transitions to Community Living (Commission). The Commission shall (i) examine the State's system of community housing and community supports for people with severe mental illness, severe and persistent mental illness, and intellectual and developmental disabilities and (ii) develop a plan that continues to advance the State's current system into a statewide system of person-centered, affordable services and supports that emphasize an individual's dignity, choice, and independence. In the execution of its duties, the Commission shall consider the following:

(1) Policies that alter the State's current practices with respect to institutionally based services to community-based services delivered as close to an individual's home and family as possible.
(2) Best practices in both the public and private sectors in managing and administering long-term care to individuals with disabilities.
(3) An array of services and supports for people with severe mental illness and severe and persistent mental illness, such as respite, community-based supported housing and community-based mental health services, to include evidence-based, person-centered recovery supports and crisis services and supported employment.
(4) For adults with intellectual and other developmental disabilities, expansion of community-based services and supports, housing options, and supported work. Maximize the use of habilitation services that may be available via the Medicaid "I" option for individuals who do not meet the ICF-MR level of need.
(5) Methods to responsibly manage the growth in long-term care spending, including use of Medicaid waivers.
(6) Options for repurposing existing resources while considering the diverse economic challenges in communities across the State.
(7) Opportunities for systemic change and maximization of housing, and service and supports funding streams, including State-County Special Assistance and the State's Medicaid program.

(8) The appropriate role of adult care homes and other residential settings in the State.

(9) Other resources that might be leveraged to enhance reform efforts.

SECTION 10.23A.(c) The Commission shall be composed of 32 members as follows:

(1) Six members of the House of Representatives appointed by the Speaker of the House of Representatives.

(2) Six members of the Senate appointed by the President Pro Tempore of the Senate.

(3) Secretary of the Department of Health and Human Services (DHHS) or the Secretary's designee.

(4) Director of the Housing Finance Agency or the Director's designee.

(5) Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of DHHS or the Director's designee.

(6) Director of the Division of Medical Assistance of DHHS or the Director's designee.

(7) Two mental health consumers or their family representatives.

(8) Two developmental disabilities consumers or their family representatives.

(9) Two persons in the field of banking or representing a financial institution with housing finance expertise.

(10) Two representatives of local management entities/managed care organizations.

(11) A county government representative.

(12) A North Carolina Association, Long Term Care Facilities representative.

(13) A North Carolina Assisted Living Association representative.

(14) A family care home representative.

(15) A representative of group homes for adults with developmental disabilities.

(16) A representative of group homes for individuals with mental illness.

(17) Two representatives of service providers with proven experience in innovated housing and support services in the State.

The Secretary of the Department of Health and Human Services shall ensure adequate staff representation and support from the following: Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Division of Aging and Adult Services, Division of Health Services Regulations, Division of Social Services, and other areas as needed.

The Commission shall appoint a Subcommittee on Housing composed of 15 members and a Subcommittee on Adult Care Homes.

The chairs shall jointly appoint members described in subdivisions (7) through (17) of this subsection and shall fill vacancies in those positions. The Commission shall meet at the call of the chairs. Members of the Commission shall receive per diem, subsistence, and travel expenses as provided in G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Commission may contract for consultant services as provided in G.S. 120-32.02. Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Commission in its work. Clerical staff shall be furnished to the Commission

through the offices of the House of Representatives and Senate Directors of Legislative Assistants. The Commission may meet in the Legislative Building or the Legislative Office Building. The Commission may exercise all of the powers provided under G.S. 120-19 through G.S. 120-19.4 while in the discharge of its official duties. The funds needed to support the cost of the Commission's work shall be transferred from the Department of Health and Human Services upon request of the Legislative Services Director.

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SECTION 10.23A.(h) The Commission shall issue an interim report by October 1, 2012, and a final plan to the 2013 General Assembly no later than February 1, 2013, at which time the Commission shall expire.

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